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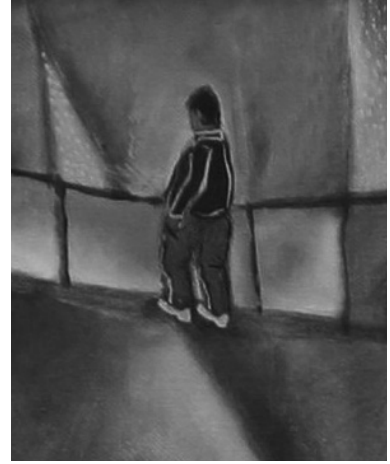
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## **Treatment of asylum seekers: resilience-oriented therapy and strategies (ROTS): implications of study results into clinical practice**

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## Introduction

In several articles (Laban et al., 2004, 2005, 2007, 2008) we described an epidemiological study among Iraqi asylum seekers in the Netherlands. The results of this study have important implications for political and policy decision makers at local and (inter)national levels, and for health workers involved in screening, referral and prevention.

The present article focuses on the implications of the study for mental health professionals in a treatment setting. After a summary of the results of the study and a short description of the treatment centre, we will discuss the concept of resilience and describe a resilience-oriented diagnostic and treatment model. Subsequently we will discuss some resources of resilience and illustrate the applications in clinical practice. The main purpose of this chapter is to show that, although the limitations in the treatment of asylum seekers are substantial and the powerlessness of the asylum seeker is sometimes overwhelming the health worker, it is nevertheless possible and sensible to offer mental healthcare for this group.

## Summary of study results and consequences for treatment

In a national community-based study among Iraqi asylum seekers in the Netherlands (Dutch Study Iraqi Asylum Seekers), we measured the prevalence of psychiatric disorders, functional disability, quality of life, somatic illness, health service use and a diverse set of risk factors. The study focused on the impact of a long asylum procedure on their health status, and therefore the entire group was prestratified based on the length of stay. The first group (n=143) had recently arrived (less than six months) and the second group (n=151) stayed more than two years in the Netherlands. Respondents were interviewed in their own language, with fully structured, culturally validated, and translated questionnaires (Laban et al., 2004).

Table 1 shows some socio-demographic data and the key prevalence figures of some risk factors and outcome measures of the study. The average level of co-morbidity was high: e.g., among the respondents with post-traumatic stress disorder (PTSD) (36.7%), 64.7% also had a depressive disorder, 34.3% an other anxiety disorder and 15.7% a somatoform disorder. Overall, the co-morbidity was higher in group 2. Multivariate regression analyses showed that 'length of stay' was the biggest risk factor (after female sex) for having a psychiatric disorder (odds ratio 2.16) and that various clusters of post-migration living problems (PMLP) had a significant negative effect on mental health: lack of work (OR 1.37), family issues (OR 1.19) and items

**Table 1.** Socio-demographic, adverse life events, post-migration living problems and health characteristics in at random samples of Iraqi asylum seekers arrived < six months (group 1) versus > two years (group 2) in the Netherlands, 2000-2001

Variables	Group 1 (n=143)	Group 2 (n=151)	Total (n=294)	P value
Stay in months (mean, SD)	2.51 (1.16)	36.77 (6.30)	20.12 (17.76)	$p<0.0005$ , T(292)=63.66
Sex (%)				$p<0.0005$ , $\chi^2(1)=27.31$
Male	49.7	78.8	64.6	
Female	50.3	21.2	35.4	
Age (mean, SD)	35.5 (14.7)	35.3 (10.7)	35.4 (12.8)	n.s.
Adverse life events (%)				
Till 13st year	22.4	37.1	29.9	$p=0.006$ , $\chi^2(1)=7.58$
Between 13st year and departure	61.5	73.5	67.7	$p=0.028$ , $\chi^2(1)=4.81$
Between departure and arrival	23.1	51.0	37.4	$p<0.0005$ , $\chi^2(1)=24.44$
After arrival	14.0	46.4	30.6	$p<0.0005$ , $\chi^2(1)=36.23$
Post migration living problems (mean, SD)				
Family related issues <sup>1</sup>	36.54 (26.55)	52.81 (24.24)	44.90 (26.62)	$p<0.0005$ , T(292)=-5.49
Discrimination <sup>1</sup>	2.05 (7.92)	11.17 (21.01)	6.74 (16.65)	$p<0.0005$ , T(292)=-4.87
Asylum proc. related issues <sup>1</sup>	48.58 (25.35)	60.13 (23.23)	54.51 (24.97)	$p<0.0005$ , T(292)=-4.07
Socioeconomic living conditions <sup>1</sup>	22.35 (19.16)	32.48 (21.08)	27.55 (20.76)	$p<0.0005$ , T(292)=-4.30
Socio-religious aspects <sup>1</sup>	12.96 (17.46)	14.48 (17.19)	13.74 (17.31)	n.s.
One or more psychiatric disorder (%)	42.0	66.2	54.4	$p<0.0005$ , $\chi^2(1)=17.44$
Anxiety disorder (cluster)	14.0	30.5	22.4	$p=0.001$ , $\chi^2(1)=11.45$
Depressive disorder (cluster)	25.2	43.7	34.7	$p=0.001$ , $\chi^2(1)=11.14$
Somatoform disorder (cluster)	4.9	13.2	9.2	$p=0.013$ , $\chi^2(1)=6.14$
Post Traumatic Stress disorder	31.5	41.7	36.7	n.s.
Alcohol dependence	0	6.6	3.4	$p=0.002$ , $\chi^2(1)=9.80$
Overall Quality of life (mean, SD) <sup>2</sup>	2.88 (0.99)	2.23 (1.14)	2.55 (1.11)	$p<0.0005$ , Z(294)=-5.29
Perceived QoL general health (mean, SD) <sup>3</sup>	3.06 (1.15)	2.74 (1.27)	2.89 (1.22)	$p=0.017$ , Z(294)=-2.39
Physical and Role Disability (mean, SD) <sup>4</sup>	17.31 (7.43)	19.25 (6.77)	18.30 (7.15)	$p=0.020$ , T(292)=-2.34
Days of disability (mean, SD) <sup>5</sup>	5.37 (8.24)	7.68 (9.17)	6.56 (8.80)	$p=0.024$ , T(292)=-2.27
Physical diseases (mean, SD) <sup>6</sup>	0.85 (1.18)	0.84 (0.98)	0.85 (1.08)	n.s.
Physical complaints (mean, SD) <sup>6</sup>	0.83 (1.38)	1.62 (1.58)	1.23 (1.54)	$p=0.0005$ , T(292)=4.52

<sup>1</sup> range: 0 (not worried) -100 (extremely worried about the issues)

<sup>2</sup> scale of 1 (very bad) – 5 (very good)

<sup>3</sup> scale of 1 (very bad) – 100 (very good)

<sup>4</sup> range: 11 (no impairment at all) – 33 (serious impairment)

<sup>5</sup> range: 0-31 (number of days of serious impairment in last months)

<sup>6</sup> range: diseases: 0-12; complaints: 0-6

n.s. :not significant  $p\geq 0.05$

directly related to the asylum procedure (OR 1.17). The odds ratio of life events in Iraq was lower than the risk of ‘length of stay’, although many traumatic experiences were mentioned in both groups: e.g., 30.6% experienced torture, 90.1% experienced unnatural death in the family and 7.8% lost a child.

In addition, length of the asylum procedure and various clusters of PMLP predicted lower levels of quality of life and higher levels of functional disability and physical complaints.

We concluded that many asylum seekers who are coming for treatment:

- experienced a lot of adverse life events and lost many resources
- have more than one psychiatric disorder
- have a lot of concomitant somatic health problems and complaints
- have a high rate of disability and a low quality of life
- have a lot of post-migration living problems and experience these stress factors as more important than the life events in the past.

The consequences for treatment are, in our opinion, as follows:

- The treatment should recognize the complexity of the existence and problems of asylum seekers.
- There is a need for a thorough and broad diagnostic procedure, which contains psychiatric, somatic, cultural and spiritual evaluation, in a safe, inviting and transparent setting.
- The treatment should be directed to alleviate symptoms of a wide range of psychiatric disorders, diminish functional disability and improve quality of life.
- The treatment should not primarily focus on adverse and/or traumatic experiences prior to arrival but pay serious attention to daily living problems and the enduring stress generated by the asylum procedure.
- The treatment should be resilience-orientated.

### **De Evenaar, Centre for Transcultural Psychiatry**

‘De Evenaar’ (Dutch for The Equator), Centre of Transcultural Psychiatry North Netherlands in Beilen is part of a regional institute for community mental healthcare in the province of Drenthe. The centre started in September 2002 and is presently (February 2009) treating about 200 patients, coming from many conflict areas in the world (e.g., Azerbaijan, Armenia, Bosnia, Kosovo, Serbia, Congo, Sierra Leone, Afghanistan, Iraq). The centre runs several intensive group therapy programmes in the day clinic (programme from 9.30 till 15.30 h.) and the outpatient clinic. Most patients are adult asylum seekers, but an increasing number has a residence permit (refugees and migrants). Children are seen with their parents and more services for youths are planned. Patients can make use of a broad variety of services and activities which are provided by the institute. The centre works together with a range of other professionals

and organizations (social workers, nurses and doctors in the asylum seekers centres, general practitioners, departments for family therapy, the Refugee Council and its volunteers, schools, day activity centres, lawyers, etc.). The general goal of treatment is: working together with the patient to reduce complaints, to improve coping and functioning, to reconnect past and present life, to restore connections with others, and to (re)create one's life perspective. In addition to patient care, the centre is offering 1) structural and ad hoc consultations, 2) schooling activities (symposia, courses, clinical meetings), 3) consultation by a cultural anthropologist to determine the cultural formulation of diagnosis?, 4) second opinions, e.g., for forensic psychiatric institutions, 5) prevention, i.e. preventive activities such as drama lessons at school, courses on health and stress in asylum seekers centres, and family meetings for psycho-education, are organized, and 6) mental health consultation is given to medical staff and social workers in all neighbouring asylum seekers centres.

The [mental health] staff is a multidisciplinary team, including: psychiatric nurses, a family therapist, cultural anthropologist, body movement therapist, drama therapist, art therapist, activity therapist, psychologist, psychiatrist in training and a psychiatrist.

De Evenaar works in a network of associated centres for transcultural psychiatry and trauma treatment and is a member of the International Rehabilitation Council for Torture Victims.

### **ROTS: Resilience-Oriented Therapy and Strategies**

The complexity of the problems of asylum seekers which is described in the study reduces the applicability of routine protocols and practices substantially. The use of protocols requires a safe and stable environment, and besides, protocols usual deal with only one psychiatric diagnostic category or with one disorder. Moreover, the experience is that most asylum seekers are not ready and able to go through these procedures and that results are modest at best. Since its existence De Evenaar has been searching for new strategies and gradually we developed a resilience-oriented approach to meet the specific needs of our target group.

The 'resilience-oriented therapy and strategies' model (ROTS) brings together the concepts of vulnerability and stress and two aspects of resilience, i.e. personal strength (e.g., coping) and social support. In Dutch, the acronym of this model is SSKK: *stress*, *support*, *kracht* (strength) en *kwetsbaarheid* (vulnerability). The model was first described by De Jonghe et al. (1997). It recognizes the multifactorial etiology of psychopathology and puts emphasis on the importance of personal strength and

potentials of recovery. To emphasize the importance of resilience in the model we decided to change the name to: Resilience-Oriented Therapy and Strategies (ROTS). The Dutch word 'ROTS' means rock. Before we will explain more about this model, we will shortly discuss the concept of resilience.

### **Resilience**

The term 'resilience' is related to the Latin word 'salire' which means: jump, bounce, and also splash (of water), 'resilire' means to bounce back or to splash again (like in a fountain). Rutter (2006) defined resilience as a concept that refers to a relative resistance to environmental risk experiences, or the overcoming of stress or adversity. The theoretical roots of the concept were described in earlier years, mainly in relation to children (Rutter, 1985, 1987; Zigler & Glick, 1986; Masten et al., 1990, Luthar et al., 2000). In recent years the concept of resilience and a diverse range of resources of resilience have been the subject of theoretical, psychological as well as biological studies (Charney et al., 2004; Southwick et al., 2005; Yehuda et al., 2006; Rutter, 2006; Ozbay et al., 2007).

With regard to asylum seekers one could define resilience as *the capacity to maintain or regain health and function ability despite past experiences and to endure stressors of the asylum procedure and all daily living hassles (post-migration living problems)*.

The concept of resilience is still in debate. Some argue that resilience has become an umbrella term to cover many aspects of overcoming adversity and adapting to one's environment. This variability in the application of the construct of resilience has led to some confusion and controversy in the definition and utility of resilience and whether it is a valuable construct that can be empirically examined, studied, and utilized in interventions (McCubbin, 2001). Vanderbilt and Shaw (2008) reviewed studies on resilience and concluded that resilience may benefit from a narrower conceptualization focusing on specific outcomes at specific time points. According to them "the breadth of the concept of resilience can be frustrating, however part of the appeal of the concept is that it *does* cut across so many areas of research".

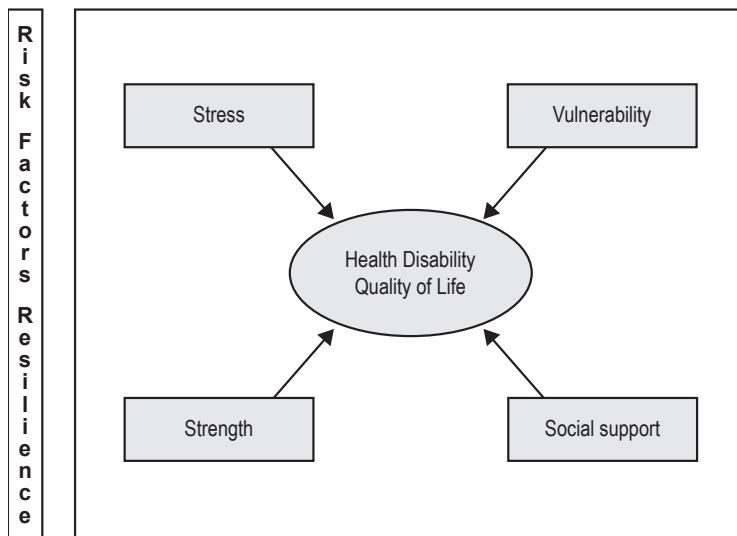
Focusing on resilience in the treatment setting implies a shift from focusing on symptoms to enhancing recovery (from complaint to strength, in Dutch: 'van klacht naar kracht').

In the ROTs model two aspects of resilience are considered: personal strength and social support. An important characteristic of social support compared to other

resilience factors is the fact that social support is coming from outside a person (exogenous) and that all the other factors are factors within a person (endogenous).

## The ROTS model

The model is an expansion of the well-known Stress Vulnerability Model developed by Zubin and Spring (1977) (De Jong, 2002; Ingram & Luxton, 2005). The hypothesis in this model is that health complaints will occur when the level of stress exceeds the (biological or psychological) capability of a patient. In the ROTS model, the factors social support and personal strength are added. Social support can be divided in several categories (see later). Personal strength implies all abilities to bear, cope, solve, and live on after adverse life events. Both factors can eliminate or reduce the impact of stress and vulnerability and are considered resilience factors. Consequently, the ROTS model (Figure 1) is based on the afore mentioned concepts of vulnerability and stress as risk factors, and personal strength and social support as resilience factors.



**Figure 1.** Resilience-oriented model (adapted from De Jonghe et al. 1997)

Vulnerability and strength are considered personal characteristics (internal factors) and stress and social support are considered ecosocial characteristics (external factors). It is assumed that a dynamic equilibrium between these factors is required to remain or become a healthy person. Health, disability and quality of life are affected by all



four factors. The rectangle around the core model reflects the interactions between the factors. However, for the sake of practical use we did not include more lines in the picture of the model.

In our view the model has some important advantages:

1. It emphasizes the healing ability (resilience) of the patient, instead of focusing solely on stressors and complaints.
2. It helps in finding protective, supporting and strengthening factors (resources of resilience).
3. It challenges to investigate a broad scope of interventions tailored to the individual situation and characteristics of the patient.
4. It is very easy to explain to staff members as well as to patients and their families.
5. It gives a shared frame of reference.
6. It heavily involves the patient in his or her own healing and/or surviving process.

All treatment interventions are directed towards lowering stress and vulnerability and increasing resilience (social support and personal strength).

### **Resilience-oriented approach: consequences for assessment and treatment**

The ROTS model helps in the diagnostic process to gather information about relevant factors that are possibly related to the health complaints. When the model is adequately applied, the assessment leads to all kinds of ideas for interventions.

*Stress:* what are the past and present sources of stress? Which of them can be changed and which of them can not (facts and perception)?

*Vulnerability:* life history (youth), family history, genetics, chronic diseases and complaints, feelings of shame and guilt.

*Social support:* what people are important (nearby, far away, dead, alive), in what way do they support the patient/the family?

*Strength:* what is giving the strength to live on, to continue to try to make things better? What is making life still worthwhile to live? In case of suicidality: what protected a patient from taking her/his life? Moreover other questions can be included, e.g., about character (optimistic, pessimistic, usual way of coping with changes), personal examples/role models, coping with past and present problems, language abilities, abilities to ask for help, meaning of religion, perspectives/hope for the future, etc.

Cultural factors can play a role in all factors of the model and should be addressed adequately. Usually, the therapist does not know a lot about these factors and needs to inquire about them actively. The attitude that works best here is probably best described as ‘respectful anxiousness’. In very complex situations the model can very well be explained to the patient (and his/her family). Subsequently, all the factors can be filled out in mutual cooperation.

### **Resources of resilience**

The resources of resilience which are discussed below are based on findings in the literature and on our own clinical experience. The resources are often related to one another, but for the sake of clarity, we classify them according to the bio-psycho-social model: *biological* (physical exercise, understanding the body, relaxation, treatment of medical illnesses), *psychological* (positive emotions and humour, acceptance, cognitive flexibility, empowering self-esteem, active coping), *social* (social relatedness, reconnecting the family, creating social support), *cultural* (cultural identity, acculturation, language skills), and *religious/spiritual* resources.

### **Biological resources**

#### *Understanding the body*

Educating/informing patients about the physical symptoms of and reactions to (traumatic) stress is an important first step towards control and reduction of fear and its value has been recognized widely (Van der Kolk, 1996, 2006; Levine, 1997; Rothschild, 2000; Horowitz, 2005). Patients are offered an explanatory biological and psychological model of their symptoms to understand their own symptoms and reactions in order, subsequently, to get a grip on their own healing and resilience process. Although the effectiveness of this type of education is not yet studied (probably because it is always seen as complementary to the ‘official’ treatment, combining education and body-oriented activities in one programme appears to be essential to bring along changes in relatively fixed action patterns/routine ways of dealing with past and present stress.

#### *Physical exercise*

Research has been done on the effectiveness of physical exercise training in the treatment of depression (Stathopoulou et al., 2006; Babyak et al., 2000; Blumenthal et al., 1999), and to a lesser extent, of PTSD (Manger, 2005). Blumenthal et al. (1999) reported significant reductions in depression scores among subjects treated with

16 weeks of aerobic exercise. The reduction was similar to sertraline or a combination of aerobic exercise and sertraline. Six months after the interventions, patients who had aerobic training had better results than patients from the other groups, especially the ones that continued to exercise at home (Babyak et al., 2000). In a meta analysis with eleven studies, Stathopoulou et al. (2006) concluded that physical exercise was a powerful intervention in depressive disorders. A preliminary study (Manger & Motta, 2005) assessed the impact of a twelve-session aerobic exercise programme on symptoms of PTSD, anxiety and depression and found positive results. One recent study (Arnson et al., 2007) shows that physical exercise in male patients with combat-related PTSD provides protection from future development of somatoform disorder. Neurobiological research has shown that exercise induces expression of multiple genes known to be involved in plasticity and neurogenesis in the hippocampus (Cotman & Berchtold, 2002; Elder et al., 2006).

In conclusion, educating patients on the importance of exercises, making training schedules for them, organizing a guided exercise programme (by physiotherapists and movement therapists) are all means to increase positive effects of exercise on the process of resilience.

### *Stress management/relaxation*

Bisson & Andrew (2007) found that stress management (SM) and trauma-focused cognitive behaviour therapy/exposure therapy (TFCBT) were equally effective in the treatment of PTSD. Stress management interventions vary widely in content and duration and may include progressive muscle relaxation (Jacobson, 1965; Ehrenreich, 1999). This type of SM is still widely used and considered to be a safe and accessible technique to reduce mental stress. As many traumatized patients are not aware of their bodily sensations, the technique is a nice start to connect body and mind. Recently, meditation and mindfulness have been shown effective in reducing stress, as indicated by lowering of cortisol levels (Baer, 2003). CBT-mindfulness reduced the risk of a relapse of depression (Teasdale, 2000) and alleviated anxiety and depressive complaints (Santorelli, 1992; Reibel et al., 2001). Mindfulness focuses on being completely in touch with and aware of the present moment, as well as taking a non-evaluative and non-judgmental approach to inner experiences. Although traumatized individuals tend to feel overwhelmed or deny an inner sense of themselves, elements of these techniques can readily be used: learning the difference between emotions and bodily sensations and between various emotions (anger, fear, sadness), learning techniques (breathing, movements, thoughts, etc.) on how to deal with stress, and

experiencing that remembering the past does not inevitably result in overwhelming emotions. All these aspects increase the persons ability to cope with stress, which is an important element related to resilience.

### *Medication*

Specific aspects of pharmacotherapeutic interventions in refugee populations are described (e.g., Kinzie & Friedman, 2004). However, in daily practice in the treatment of asylum seekers it is not always easy to find effective medication for the individual patient. Co-morbidity, a wide variety of symptoms, high sensitivity to side-effects, different genotypes, and compliance problems are all factors to deal with (Kortmann & Oude Voshaar, 1998; De Jong, 2006; Han & Liu, 2005). In order to lower the resistance to using medication and to improve intake, it might be helpful to discuss medication in the context of resilience. Special focus on the most wearing symptoms (e.g., sleeping problems, nightmares, pain) and the supportive (but often non-curative) character of the medicine is important, next to adequate monitoring and explaining the working mechanism and potential side-effects.

### *Treatment of non-psychiatric illnesses*

Several studies show high rates of physical diseases and complaints in asylum seekers (Laban et al., 2008; Gerritsen et al., 2006). Chronic physical health problems have a negative impact on functioning and quality of life (Laban et al., 2008). The relationship between physical complaints and depression is well established (e.g., Simon et al., 1999). PTSD appears to be a particular risk factor for several chronic diseases (Weisberg et al., 2002). These diseases are a threat to the resilience process. In order to limit their impact adequate diagnoses and treatment of these non-psychiatric illnesses is important.

## **Psychological resources**

### *Positive emotions and humour*

Negative emotions narrow one's momentary thought-action repertoire by preparing one to behave in a specific way (e.g., attack when angry, escape when afraid). In contrast, positive emotions (e.g., joy, interest, satisfaction, pride, love) broaden one's thought-action repertoire and improve coping mechanisms such as positive reappraisal and goal-directed problem-focused coping (Folkman & Moskowitz, 2000; Frederickson, 2001; Tugade & Frederickson, 2004). Positive emotions also broaden one's focus of attention in reliance to creativity, exploration and flexibility in thinking.

Also humour has been described as a source of resilience (Southwick et al., 2005). Humour appears to reduce the threatening nature of a situation through cognitive reappraisal (Juni & Katz, 2001). Positive emotions as well as humour tend to decrease autonomic arousal. Mobbs et al. (2003) showed that humour engages a network of subcortical regions including the nucleus accumbens and the amygdalae, which plays a well-known role in fear and fear-related behaviour.

Helping asylum seekers find distracting activities, areas of pride and episodes of joy might not only reduce stress, but also improve coping. Examples of these activities within the reach of most mental health institutions are occupational, music and movement therapy. Otherwise, local opportunities (e.g., voluntary work, a local theatre project) can be used. Also, in all conversations with asylum seekers the mental health worker should look for opportunities to enhance positive emotions: positive feedback, empowering remarks, something to laugh about. If children are around, this may assist in bringing about the desired emotions.

### *Cognitive flexibility*

Cognitive flexibility is exemplified by positive reframing, or reappraisal, and refers to the ability to reinterpret an adverse or negative event so as to find meaning and opportunity (Yehuda et al., 2006). A recent brain-imaging study has shown that cognitive reappraisal brings about decreased activation of the amygdalae (Ochsner et al., 2002). CBT provides an evidence-based therapy for depression (Kuijken et al., 2007) and CBT and exposure therapy have been proven effective in PTSD treatment in various populations (Foa & Meadows, 1997; Bradley et al., 2005). Some (small) studies focus on asylum seekers (Basoglu et al., 2002) and refugees (Paunovic & Ost, 2001), suggesting that these therapies are applicable in these specific populations, also when the therapy is done with the help of an interpreter (d'Ardenne et al., 2007). However, in many cases asylum seekers do not fulfil the criteria for these therapies (e.g., safe life situation/environment) or do not have the ability to tolerate exposure. Therefore it is necessary to find other ways to increase cognitive flexibility and reappraisal related to events in the past as well as events in the present. In our experience several methods can be applied: analyzing daily stressors individually or sharing them in a group setting creates the opportunity to learn to look at events from different angles and to reflect on the attributional styles (for example to place the blame where it realistically belongs). Furthermore, learning to find words for the variety of emotions and discovering the relationships between emotions, thoughts and behaviours (the basis of CBT) can be taught in a group. Patients can be asked to work

out examples in their daily life and subsequently train themselves to change unhealthy patterns. A daily exercise is to distract yourself from negative thoughts by thinking or doing something else. All these activities are resilience-oriented: they emphasize helping thoughts and behaviour.

### *Empowering self-esteem*

Esteem needs of every human being are for instance: to achieve, be competent, gain approval and recognition (Maslow, 1954). Self-esteem has been defined as “The experience of being capable of meeting life’s challenges and being worthy of happiness” (Reasoner, 2004). Many people that are suffering from a psychiatric disorder have a low self-esteem (Silverstone & Salsali, 2003). The authors suggest that there is a vicious circle: low esteem increases the risk of a psychiatric disorder and a disorder leads to a low self-esteem.

Asylum seekers are at risk for a low self-esteem. Carballo et al. (2004) found in a study among Bosnian war survivors that there was an “overwhelming loss of perceived power and self-esteem”. Over 25% of displaced people, for example, said they no longer felt they were able to play a useful role; even in non-displaced populations approximately 11% of those interviewed said that they had lost their sense of worth. The cumulative effect of the stressors during the asylum procedure may constitute an important risk for a low self-esteem. These experiences often lead to cognitive appraisals such as ‘I am not worthwhile’, etc.

An overall positive therapeutic attitude is as important as more specific activities directed toward the improvement of self-esteem. Being taken seriously, being welcome in therapy, receiving positive feedback by an individual therapist or a team, and being embedded in a coherent, reliable, predictable interaction, can all lead to corrective emotional experiences during which self-esteem can be restored and improved. More specific treatment interventions can be: working with patients to search for and set new (achievable) goals, to stop activities that decrease self-esteem, to recognize and change cognitions which undermine self-esteem (guilt, shame), to learn to be creative, to learn new things (e.g., a language, playing music), to be proud of what can be achieved in difficult situations, to find things to do for other people within or outside the family, to ask for feedback and to learn how to receive positive and negative feedback, to be assertive, to learn from experiences (instead of blaming one-self) etc. Also in the trauma-focused therapy sessions every opportunity should be used to emphasize strength and adequate coping to correct, restore and increase self-esteem.

### *Coping*

Coping has been defined as conscious attempts to manage internal or external stressors (Folkman et al., 1986). It can be divided in active, approach-based coping (resolving or conquering the stressor) and passive, avoidance-based coping (avoiding either to think about the stressor or controlling the associated affect) (Moos, 1995). The way an individual copes with stress is thought to mediate the possible negative influence of stress on physical and mental health. In general, resilient individuals have been described as using active coping mechanisms when dealing with stressful life situations (LeDoux & Gorman, 2001). Possibly, if circumstances can not be changed a more passive coping style might be more adequate and healthy. Consequently, the most important ability is to be able to vary in coping styles, depending on the situation.

Asylum seekers have to cope with many stressors. Working on resilience is working on coping. The difference between the two concepts is that the starting point in the resilience-oriented approach is one's motivation, drive, personal strength rather than the more technical behaviour in the coping-oriented approach. The resilience-oriented approach involves trying to create the conditions in which a more adequate coping can emerge and subsequently, discussing with the patient which techniques can be used that fit the circumstances and the personal style.

### **Social resources**

#### *Social relatedness/connectedness to the family*

Family resilience has been examined in various studies. According to Walsh (2003, 2007) the resilience of families has a particular dynamic that is different from the combined resilience of separate individuals. She developed a 'family resilience framework' consisting of three domains: *family beliefs* (the extent in which a common view of reality exists), *organizational patterns* (the manner in which the family is organized) and *communication/problem-solving* (the ways of communication and searching for solutions to problems). Among asylum seekers families we often observe problems in one or more of these domains. At De Evenaar, the above-mentioned domains are analysed with the help of the ROTS-model:

*Stress*: what are the problems and how are these assessed by each member of the family?

*Vulnerability*: what should they focus on together to avoid the problems becoming bigger?

*Social support:* who assists in solving the problems, which members of the family receive such support and which not?

*Strenght:* how does the family try to solve the problems; what helped in the past; who helps whom in the family, what makes the family a family, what are they proud of as a family?

Such an analysis also makes clear in what way a family is organized and embedded in its environment (AZC, neighbourhood, countrymen, church, school, assistance, etc.). Continuously, the resilience potential of each individual member and of the family as a whole are monitored and attention is paid to how to strengthen this resilience. In our experience, the model offers a good opening to discuss or observe all domains of Walsh's framework. In this working method, resilience is not seen as an individual quality, but as something occurring – or not – in interaction with other family members and the wider environment.

It is important to give space to the complex social-societal context in dialogues with asylum seekers and refugee families. It can be tempting to forget this context and concentrate solely on solutions within the family, however the outside reality can yield a lot of stress, which one cannot avoid. Talking about for instance life in the AZC, a negative decision in the asylum procedure, discrimination, or lack of money should not be seen as an interruption of the actual therapy. Family therapy with this target group is often a search, in which one should take into account unexpected and sometimes unknown stressors. The joint learning on how to deal with these stressors can make this family grow.

### *Social support*

The feeling of belongingness, being affiliated with others, being accepted and loved is one of people's basic needs (Maslow, 1954; Sandler, 2001). Asylum seekers have lost many of their social contacts and building up a new social network is difficult for example due to frequent moves, lack of money, language problems, cultural problems. Extensive research has been done on the influence of social support on health. The division in emotional, practical, informational and 'esteem' support (Schwarzer & Leppin, 1999) is often used and makes sense in practice. Positive relations have been found in the general population (e.g., Schwarzer & Leppin, 1999; Southwick et al., 2005) as well as in refugee populations (Gorst-Unsworth & Goldenberg, 1998; Ahern et al., 2004). The lack of social support on the other hand increases the chance of psychiatric problems (Southwick et al., 2005). In neurobiological research (Heinrichs



et al., 2003) it appears that social support interacts with oxytocine (a neuropeptide affecting attachment) in lowering the cortisol levels and decreasing the response to psychological stress.

Interventions should start with an analysis of the extent and nature of social support. Many patients only have a vague idea about their own wishes with regard to social support; they do not know what type of support they can get from whom and where they can access this particular type. They therefore ask or expect a particular type of support from the wrong people (e.g., practical support from a psychiatrist and emotional support from a traumatized spouse). Some patients feel ashamed to ask for help. They must learn that even though one's own strength is always necessary, asking for support is not shameful and receiving support sometimes even is a right. Other patients ask for help in an inadequate manner. Here also cultural aspects can play a role: in some cultures you can only receive support if you act like you are completely powerless and treat the other as being superior. In the Netherlands, such an attitude will only cause irritations; your chances of being supported are larger if you tell someone what you have already tried yourself and what you would require the other to do. In conclusion, there are all sorts of possibilities for increasing (a chance on better) social support and this is of great importance with regard to resilience.

### *Meaningful activities*

One of the most important risk factors for a psychiatric illness among asylum seekers is worrying about not having work (Laban et al., 2005). In an earlier study among refugees and native Canadians, Beiser et al. (1993) found a significant relationship between unemployment and depression. The same connection was also found later in a longitudinal study (Beiser & Hou, 2001), in which depression followed unemployment, especially among men.

Asylum seekers in the Netherlands can only work a limited number of weeks per year (in 2008, 16 weeks) and because of many practical problems or limitations arising from psychological problems, only a few succeed to do that. Doing volunteer work is possible for asylum seekers, however, volunteering is an unknown phenomenon among many of them. Explanation and cooperation are thus necessary. Many mental healthcare institutions offer all sorts of activity therapy and can refer to Day Activity Centres (DAC). The value of participation in such activities should not be underestimated.

People feel better able to perform, they come in contact with others, they simply are in another environment, etc. The main purpose of this type of activity is breaking through the feelings of powerlessness and isolation and derive meaning from the activities. However, it is clear that in the end, full participation in the job market should follow on these activities. Unfortunately, there are often many obstacles to overcome and drop-out and medicalization of social problems is a real threat.

### **Religious/spiritual resources**

Religion as well as spirituality concern feelings, thoughts with regard to the meaning of life, and connectedness to a higher power or a higher dimension (Latin: *religare* means 'to connect'). The word religion usually points to a more rigid, organized form of spirituality. Because the term spirituality is more difficult to define, scientific research has focused nearly exclusively on religion. The interest in the relation between religion and health has increased tremendously over the last decades, with regard to the prevention, the coping with as well as the recovering from (physical and psychological) illnesses.

Review articles (Harrison et al., 2001; Matthews et al., 1998) show that religion in general has a positive influence on all these aspects. Research has also been done in the Netherlands on this topic (Pieper & Van Uden, 2005). However, little research is available on the possible protective and supportive role of religion for asylum seekers/refugees. Schweitzer et al. (2007) examined coping and resilience in a small group (13) of Sudanese refugees and found that besides social support, religion was the most important source of resilience. In our study among almost 300 Iraqi asylum seekers, we found that 77.6% of them considered religion to be moderately to very important (this data are not published yet). Compared to the period before the flight, 63.9% of respondents trusted in God/Allah in an equal manner and 29.6% had higher trust.

Engelhard and Goorts (2005) interviewed 120 asylum seekers and refugees. One third of the respondents saw their problems as a test of God/Allah, and half considered God/Allah the originator of their problems. Most respondents from both groups however mentioned that God/Allah had been a source of support and comfort. The authors did not find a difference between Christians and Muslims. Some respondents identified themselves with persons described in holy texts, like the figure of Job in the Bible.

In the mental health practice for asylum seekers it makes sense to talk about religion in a standardized way, as part of the diagnostic process as well as during treatment. Most of them come from countries where religion is an integral part of life and in

general they think it is normal to be asked questions about this subject. In many ways religion can play a role in their life. For instance: religion can be the cause of their flight (e.g., Christians from Iraq); can strongly influence their lifestyle (food habits, manners, clothing); can be a ‘trouble-maker’ (e.g., when a patient continuously wonders whether God/Allah is for or against him/her); can be an explanation for their feeling unwell (break of taboos, having been disobedient, etc.); can play a role in mutual conflicts; and can contribute to getting into contact with new people or not.

In connection to resilience, religion can be considered an interpretation frame, it can strengthen one’s ‘connection to life’ (and become for instance a protective factor against suicide), it can give the feeling to be part of a greater union, it can give emotional support and also social support of co-religionists and communities. In short, religion can be an important source of resilience and therefore it is imperative to pay attention to it continuously.

### **Cultural resources**

Even though the literature about culture and psychiatry has grown quickly over the last decades, there are only a few publications about culture as a resource for resilience (Jong de, 2002; Peddle, 2007; Tummala-Narra, 2007). The focus of culture and psychiatry is mainly on the necessity of knowing elements of the culture of the patient, recognizing culture-specific syndromes, paying attention to differing explanations for being ill, and of being able to take into account cultural elements during contacts and conversations in the diagnostic and in the treatment phase. These are all very relevant points of attention, however it would be wrong to disregard culture as a source of resilience.

Tummala-Narra (2007) identifies a number of important points concerning trauma and resilience in a multicultural context: 1) resilience is not an individual process but always takes shape in interaction with the family and wider environment, especially in group-oriented cultures, 2) recovery of trauma means among other things that you redefine the image you have of yourself, this is also true for the acculturation process; thus it concerns in fact a double-identity adaptation, 3) fear related to trauma can be increased through negative confrontations in the guest country (discrimination, lack of understanding, hostility), 4) many people come to a new country with the hope of a better life. Even though some expectations need to be adjusted, many people remain hopeful. This can be a source of resilience, especially if this hope is being shared with others. 5) Artistic expressions (e.g., writing, painting, making music) can be important

in the recovery phase as well as in the acculturation process, to bridge the gap between ‘then and now’ and ‘there and here’.

Recent Dutch studies (Kamperman et al., 2005; Knipscheer & Kleber, 2007) show that the right balance between holding on to the own culture and opening up to and participating in the new culture, gives the best chance on a good health.

In conclusion, attention paid to the process of acculturation and identity is of large interest to the treatment; especially if one looks for cultural aspects (values, norms, customs, skills, etc.) that can be a source of resilience for the patients and their families.

One of the ways to discover these aspects is by discussing the following topics:

- meaning of the trauma in the cultural/social context of then and now;
- political reality/development in comparison to the individual story of the patient;
- looking for aspects of the cultural identity that increase coping (e.g., music);
- possibilities for participation in (e.g., refugee) organizations;
- meaning of and possibilities for cultural celebrations in the family/group;
- which rituals, stories, metaphors, proverbs with regard to resilience are important;
- importance of integration with regard to health.

The forms in which these subjects can be discussed can differ. Using the Cultural Formulation of Diagnosis (APA, 1994) and the Cultural Interview (Rohloff et al., 2002; Groen, 2008) is a good start. Further exploration can take place in individual sessions, but preferably also in group discussions. Exchange of cultural customs, norms, values etc. may help someone to get to know his/her own culture better and may increase one’s understanding of the extent to which one is different. Only then can someone reflect on which elements one would like to keep, and which aspects can help him/her in the present life. A lot depends also on the hospitality of the new country and which new cultural resources someone is offered there.

## Conclusion

The problems of asylum seekers are numerous and a high percentage have or develop physical and mental health problems. They perceive serious disabilities and a low quality of life. Treatment possibilities are limited due to the experienced complex trauma’s, the ongoing stress and the existence of co-morbidity of stress-related psychiatric disorders. Notwithstanding these limitations, however, treatment is possible. We described a resilience-oriented diagnostic and treatment model in which

the concepts of stress, vulnerability and resilience (distinguished in personal strength and social support) are incorporated. In our opinion this model is very well applicable in all treatment modalities with asylum seekers.

For humanitarian reasons this group needs our attention and there is no professional reason to deny this group mental healthcare. So all financial and logistic facilities should be created and ensured to enable asylum seekers to get the help they often so desperately need.

## **References**

For a complete list of references we refer to the back of the thesis.